

UNITED STATES BANKRUPTCY COURT
DISTRICT OF DELAWARE

IN RE: . Case No. 01-1139 (JKF)
. .
W.R. GRACE & CO., .
et al., . USX Tower - 54th Floor
. 600 Grant Street
. Pittsburgh, PA 15219
Debtors. .
. January 22, 2008
. 9:07 a.m.
.

TRANSCRIPT OF TRIAL
BEFORE HONORABLE JUDITH K. FITZGERALD
UNITED STATES BANKRUPTCY COURT JUDGE

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1 THE COURT: This is the continuation of the personal
2 injury estimation trial in W.R. Grace, Bankruptcy Number 01-
3 1139. The participants I have listed by phone, James Rieger,
4 Alan Madian, Lewis Kruger, Daniel Glosband, John Wollen,
5 Jonathan Brownstein, Daniel Speights, Sina Toussi, Kirk
6 Hartley, David Beane, Debra Felder, Janet Baer, Andrew Craig,
7 David Mendelson, Ellen Ahern, Jonathan Lewinsohn, John
8 O'Connell, Theodore Freedman, Mark Hurford, Jeanna Rickards,
9 Steven Mandelsberg, Jeff Waxman, Bernard Bailor, Peter
10 Lockwood, Elihu Inselbuch, Walter Slocombe, James Wehner,
11 Michael Davis, Terence Edwards, Edward Westbrook, Andrew Chan,
12 Joshua Cutler, Timothy Cairns, Jacob Cohn, William Corcoran,
13 John Phillips, Ari Berman, Seth Brumby, Katharine Mayer,
14 Christopher Candon, Alex Mueller, Tiffany Cobb, Scott Baena,
15 Jarrad Wright, David Parsons, Darrell Scott, Martin Dies,
16 Theodore Tacconnelli, Leslie Kelleher, Beau Harbour, Elizabeth
17 Devine, Jason Solganick, Matthew Russell, Robert Guttman,
18 Francis Monaco, and Shayne Spencer.

19 I'll take entries in court. Good morning.

20 MR. BERNICK: Good morning. David Bernick for Grace.

21 MR. STANSBURY: Brian Stansbury for Grace.

22 MS. HARDING: Barbara Harding for Grace.

23 THE COURT: Excuse me one second, please. Okay.

24 Thank you.

25 MR. BIANCA: Salvatore Bianca for Grace.

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1 THE COURT: Good morning.

2 MR. FINCH: Nathan Finch for the Asbestos Claimants
3 Committee.

4 MR. BAILOR: Bernard Bailor for the Asbestos
5 Claimants Committee.

6 MR. INSELBUCH: Elihu Inselbuch for the Committee.

7 MR. MULLADY: Good morning, Your Honor. Ray Mullady
8 for the Future Claimants Representative.

9 MR. ANSBRO: John Ansbro, also for the Future
10 Claimants Representative.

11 THE COURT: Good morning.

12 MS. KRIEGER: Good morning, Your Honor. Arlene
13 Krieger from Stroock and Stroock and Lavan on behalf of the
14 Official Committee of Unsecured Creditors.

15 THE COURT: Good morning.

16 MR. HOROWITZ: Good morning, Your Honor. Greg
17 Horowitz from Kramer Levin on behalf of the Equity Committee.

18 MR. KRAMER: Good morning, Your Honor. Matt Kramer,
19 Bilzin Sumberg on behalf of the Property Damage Committee.

20 MR. FRANKEL: Good morning, Your Honor. Roger
21 Frankel on behalf of the Future Claimants Representative.

22 THE COURT: Folks, I have two housekeeping matters to
23 discuss with you before we begin. One concerns the schedule
24 for tomorrow. I have a family matter, which means that I have
25 to leave here at 5:00, so whatever schedule adjustments you

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1 need tomorrow, we have to be finished at 5:00 tomorrow.

2 The second has to do with the schedule for March the
3 3rd and the 5th. Something has come up. I'm not going to be
4 able to be here those two days, so I propose to cancel the
5 trial on March the 3rd and the 5th and instead change the days
6 to May 13th and May 14th, if you're available those two days.
7 So could you please check. I've done some readjustment to my
8 schedule, so we can fill those two days in if those two days
9 are satisfactory with you. I understand that you may be asking
10 for some additional trial days. I'm not sure if that's going
11 to be necessary or not. Perhaps you can all talk and let me
12 know. If you are -- if you do think you're going to need trial
13 days, frankly, I think we better discuss that soon, because I
14 have another matter that's also going to get heated up very
15 soon that's going to take some very lengthy trial days, and I'm
16 not going to be able to do them both at the same time. So we
17 need -- I'm going to need some planning.

18 MR. BERNICK: Fine.

19 THE COURT: Okay. Mr. Bernick. Oh, sorry.

20 MR. MULLADY: Your Honor, I have one procedural issue
21 to take up with the Court.

22 THE COURT: Yes, Mr. Mullady.

23 MR. MULLADY: Good morning, Your Honor.

24 THE COURT: Good morning.

25 MR. MULLADY: Just a small procedural point that I

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1 don't think will be controversial. It's just a -- it's a
2 procedural request and suggestion for the Court that stems from
3 some moments we had last week during the examination of Dr.
4 Rodricks. I think it's fair to say that counsel for both sides
5 made statements in the presence of the witness that we believe
6 should've been communicated at sidebar. We propose that going
7 forward if counsel feel they need to make a statement or an
8 argument or an objection that's more than just to state the
9 objection and the grounds, that we ask the Court for a sidebar,
10 or that the witness be excused, so we can have the airing of
11 that discussion.

12 We don't seek a tactical advantage here. We seek
13 really to just have a level playing field and to insure that we
14 have a process that has the integrity to it that, you know, we
15 think should be followed, which is that witnesses shouldn't be
16 educated by statements or pushed in one direction or another by
17 statements of counsel. And, obviously, the Court has the
18 authority to institute a procedure like this under Federal Rule
19 of Evidence 611(a), which gives the Court discretion to -- in
20 fact, the obligation to control the method of examining a
21 witness and the preparation -- or the presentation of evidence.
22 Thank you.

23 THE COURT: All right. Is this controversial?

24 MR. BERNICK: I -- it's never been raised with me,
25 Your Honor. I just heard it for the first time this morning,

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1 so I don't have any issue with -- if there -- if it's expected
2 there will be matters that require some significant discussion
3 approaching the Court at sidebar, I also don't believe that
4 this is, frankly, that big a deal, and I don't think that it
5 would make sense to have a rigid rule that says that if you say
6 more than objection, that calls for or objection to form, then
7 immediately we then have to have a sidebar conference, which I
8 think generally takes time to get organized and interrupt the
9 flow of the examination that way.

10 THE COURT: All right. I think I'll let it up to
11 counsel to ask if they think that something is going to require
12 a sidebar to ask for it. I'm not going to do it if it's
13 simply, you know, an objection to the hearsay rule. Frankly, I
14 think most of your witnesses, to the extent that they're
15 experts, have already been educated by counsel in the requests
16 that you've been making of them beforehand anyway. They're not
17 new, most of them, to this process. They either testified or
18 been involved in writing reports in many cases not just this
19 one. So I doubt that they're very surprised by most of
20 counsel's opinions, but I'm not opposed to their request in an
21 appropriate circumstance.

22 MR. MULLADY: Thank you, Your Honor. And, obviously,
23 we're not -- the purpose of this request isn't to curb simple
24 objections of that nature, but I think if the Court were to go
25 back and read the transcript from last week -- and I'm sure

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15

1 Your Honor recalls -- there was a lot more than that that was
2 said, and it was on both sides. Again, this is not -- we're
3 not pointing fingers. We're not on a high horse. All we're
4 asking for is that if this sort of thing has to be aired, that
5 it be aired outside the presence of the witness.

6 THE COURT: All right. That's a fair request, and
7 I'll let it up to -- as I said, to both counsel to ask for it
8 when you think the circumstances -- on all sides that is -- to
9 ask for it when you think the circumstances are appropriate.

10 MR. MULLADY: Thank you, Your Honor.

11 THE COURT: Anything else before we begin?

12 MR. BERNICK: May we proceed, Your Honor?

13 THE COURT: Yes, sir.

14 MR. BERNICK: We call as our next witness Dr. David
15 Weill. Dr. Weill is here. If you could take the stand?

16 THE CLERK: Please stand and raise your right hand.

17 DR. DAVID WEILL, DEBTORS' WITNESS, SWORN

18 MR. BERNICK: Good morning, Dr. Weill.

19 DIRECT EXAMINATION

20 BY MR. BERNICK:

21 Q Could you please just tell the Court at the outset what
22 the principal focus of your testimony will be here this
23 morning?

24 A My principal focus is to speak about the attribution of
25 lung cancer by asbestos.

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16

1 MR. BERNICK: Okay. There was a chart that we showed
2 in opening here. If we could call up GG-2121?

3 Q Do you have that in front of your screen there, Dr. Weill?

4 A I do.

5 Q I explained to -- I presented to the Court what we
6 intended to do with respect to the -- what we called the
7 exposure filters part of the analysis, and I distinguished it
8 from what you see down in the bottom right-hand corner as the
9 disease filters part of the analysis. What specific matters
10 will you be focused on here?

11 A I'll be speaking about the disease matters.

12 Q Okay. Will you be offering -- will you also be addressing
13 today -- let me just ask a couple more specific points. Will
14 you be addressing certain aspects of the diagnostic criteria
15 for asbestosis?

16 A As they relate to the pulmonary function testing
17 specifically.

18 Q Okay. Apart from the pulmonary function test, will you be
19 addressing today the practices of the litigation screening
20 doctors?

21 A No, I will not.

22 MR. BERNICK: Thank you. With the benefit of that,
23 Your Honor, we'd like to go through some of the witness'
24 background and qualifications if the Court and the witness can
25 be shown GG-2117?

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Weill - Voir Dire/Bernick

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VOIR DIRE

1
2 BY MR. BERNICK:

3 Q Looking at this demonstrative, Dr. Weill, could you please
4 just take the Court briefly through your educational background
5 and your medical training?

6 A I received my undergraduate degree from Tulane University
7 in New Orleans in 1985. I then went to Tulane Medical School
8 and graduated in 1990.

9 Q Okay.

10 A After residency training at the University of Texas
11 Southwestern I did my pulmonary and critical care fellowship in
12 the early nineties at the University of Colorado.

13 Q Okay.

14 A I also did an additional one-year fellowship in lung
15 transplantation.

16 MR. BERNICK: Okay. Let's show the witness and the
17 Court GG-2118.

18 Q And again if you could simply continue on, Dr. Weill, and
19 review your further training as reflected in that
20 demonstrative?

21 A My current position is Director of the Lung and Heart/Lung
22 Transplant at Stanford University. I'm an Associate Professor
23 in the Division of Pulmonary and Critical Care Medicine. I am
24 board certified in pulmonary medicine.

25 Q On a day-to-day basis, Dr. Weill, could you tell the Court

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Weill - Voir Dire/Bernick

18

1 what it is that you do?

2 A We have a varied practice where we're referred a large
3 number of patients with a variety of advanced and early stage
4 lung diseases that are amenable either to novel medical therapy
5 or surgical therapy.

6 Q Okay, and what is it that you do in connection with that
7 practice?

8 A I specifically diagnose patients, provide a second opinion
9 about some of the lung disease issues, and then recommend a
10 treatment scheme that could either be medical or surgical
11 depending on the patient's needs.

12 Q Okay. Let's focus on asbestos. Do you have a background
13 in asbestos-related matters?

14 A Yes.

15 MR. BERNICK: I'd like to show the witness the next
16 demonstrative, which is 2119.

17 Q And again using that as our menu, Dr. Weill, if you could
18 walk the Court through the background that's reflected on 2119?

19 A I'm a NIOSH Certified B Reader which indicates proficiency
20 in interpreting x-rays for the pneumoconiosis. I also
21 participated in a visiting professorship in China at the
22 National Institute of Occupational Medicine and Poison Control.
23 I've also provided testimony in a few different governmental
24 bodies, including twice in the United States Senate and once in
25 the Texas State Legislature. And I've published in the medical

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1 literature on a variety of end-stage lung diseases, including
2 specifically in transplantation, transplant medicine, asbestos-
3 related diseases, and lung cancer.

4 Q Focusing on your experience in China and turning your
5 attention to Slide 2120, could you talk about what you did in
6 China and the relationship, if any, that that has to your
7 experience with asbestos?

8 A I was interested in seeing a more varied patient group
9 that had been exposed to a variety of occupational substances
10 and went to China for approximately one month to consult with
11 the Chinese doctors who were interested in the same field.

12 Q Okay, and what is it that you had an opportunity to do
13 there?

14 A I saw patients that had a variety of occupational lung
15 diseases. Most commonly asbestos-related diseases or silica-
16 related diseases and was able to not only see the patients
17 themselves but also review a large number of radiographs.

18 Q Okay. Have you had any activities in the area of
19 litigation? Have you served as an expert in connection with
20 litigation?

21 A Yes, I have.

22 Q Could you just describe for the Court in general terms
23 what your litigation-related activities have comprised?

24 A Over the last five to six years I've provided deposition
25 testimony and expert opinion regarding individual cases

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1 primarily.

2 Q Okay. Have you ever actually had the opportunity to
3 testify at trial, or is this your first -- your first testimony
4 in trial?

5 A I've testified once in an occupational lung disease matter
6 at trial.

7 MR. BERNICK: Okay. Your Honor, we would proffer Dr.
8 Weill as an expert in pulmonary medicine.

9 THE COURT: Any voir dire?

10 MR. MULLADY: No, Your Honor. No objection.

11 MR. FINCH: No, Your Honor.

12 DIRECT EXAMINATION

13 BY MR. BERNICK:

14 Q Let's talk about the principal focus of your testimony --

15 THE COURT: Would you like --

16 MR. BERNICK: I'm sorry. I'm trying to get through
17 this this morning, and it's bright and early.

18 THE COURT: Without objection, the witness may offer
19 an expert opinion in the field of pulmonary medicine. Okay.

20 MR. BERNICK: Thank you, Your Honor. I'm sorry.

21 BY MR. BERNICK:

22 Q Let's talk about -- let's focus immediately on the primary
23 focal point of your testimony, which is the relationship
24 between lung cancer and asbestos exposure. And I'd like to
25 just have you give a brief explanation of lung cancer to the

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Weill - Direct/Bernick

21

1 Court showing you GG-2122. Would this demonstrative assist you
2 in explaining particularly the locus of lung cancer?

3 A Lung cancer exists within the lung parenchyma, which is
4 the lung meat itself. It has many causes but is most commonly
5 caused by cigarette smoking around 90 percent of the time. The
6 issue that I was asked to address is its attribution to
7 asbestos exposure, and we'll spend the majority of my time
8 talking about that today.

9 Q Now, you indicated that lung cancer arises in the
10 parenchyma or the meat of the lung. Is that consistent with
11 what's indicated as the yellow box on 2122?

12 A Yes, it is.

13 Q Okay, and are we going to talk, as we go forward today,
14 about anatomically distinct in different areas within the area
15 of the lung?

16 A Yes.

17 Q Okay. Let's talk then about asbestos directing your
18 attention to Exhibit GG-2123. Is this a parallel slide that
19 deals with asbestosis?

20 A Yes.

21 Q Okay. Well, let me just take you through this a little
22 bit more deliberately. First of all, location. When we talk
23 about asbestos, what location in the lung are we talking about?

24 A So when we're --

25 MR. FINCH: Objection, form of the question.

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1 Asbestosis.

2 MR. BERNICK: I said asbestosis. Didn't I?

3 MR. FINCH: I thought you said asbestos.

4 MR. BERNICK: Oh, I apologize. Asbestosis. Thank
5 you.

6 Q What location are we talking about when we talk about the
7 location of asbestosis?

8 A So like lung cancer, asbestosis is also a parenchyma lung
9 disease, meaning as the yellow box indicates, it's actually
10 existing in the meat of the lung.

11 Q Okay, and parenchyma, what -- that's a longer term. Just
12 what does that refer to?

13 A It refers to the lung tissue itself.

14 Q Okay. It says fibrosis. That asbestosis is a fibrosis.
15 What does fibrosis mean?

16 A Scarring of the lung, quite literally, and a fibrotic
17 process is anything that scars a lung and is not specific to
18 asbestos-related diseases.

19 Q Okay. Now, are there other areas within the vicinity of
20 the lung that can also experience or sustain a fibrotic
21 condition as a result of asbestos exposure?

22 A Yes, that's the covering of the lung or the pleura.

23 Q Is that indicated also here on 2123? That is the
24 difference between parenchyma and pleura.

25 A The pleura in this slide would be the outside covering of

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1 the lunch where the arrows are pointing.

2 Q Okay. Okay. Now, let's go through -- do we have some
3 examples of x-rays showing what it is that you're looking for
4 when you're looking for asbestos, showing you 2124?

5 THE COURT: I'm sorry. Would you repeat the question
6 for me, please?

7 MR. BERNICK: Yes.

8 Q Showing you 2124 -- GG-2124, would that help you explain
9 to the Court the conditions that you observe in x-rays where
10 there is asbestosis present?

11 A Sure. On the left side of the panel you see a normal
12 lung, and what you're looking for are the aerated portions of
13 the lung which are black. There's also white parts of the lung
14 in a normal situation which are blood vessels that are running
15 through the lung, and that's normal. On the right side of the
16 panel you're seeing a lung that's affected by asbestosis.

17 Q Okay. In what -- and in particular, so the record is
18 clear, there's a part that's marked as -- with a circle saying
19 fibrosis. What is it that's being seen through the x-ray in
20 that portion of the x-ray?

21 A What you're looking at in the area that's circled, they're
22 small linear opacities, areas of the lung that are scarred by
23 asbestosis.

24 Q You said opacities. Does that have it's common meaning
25 that it's something that you have a hard time seeing through?

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1 A Yes, it's white. It shows up white in the lung.

2 Q Okay. Let's now talk about the relationship between these
3 two conditions that you've described, asbestosis and lung
4 cancer. Can there be asbestosis without lung cancer? Does
5 that condition arise?

6 A Yes.

7 Q Okay. Are they different diseases? That is is lung
8 cancer a different disease then asbestosis?

9 A Yes.

10 Q Okay. What about the other way around? Can you have lung
11 cancer without asbestosis?

12 A Yes.

13 Q Okay, and most common cause?

14 A Cigarette smoking.

15 Q Okay. Now, I want to focus on the particular kind of lung
16 cancer that is asbestos related -- that is asbestos-related
17 lung cancer. In your opinion, which we'll pursue, can you have
18 asbestos-related lung cancer in the absence of asbestosis?

19 A No.

20 Q Okay. Do you have a slide that frames in more precise
21 terms that question. That is --

22 MR. BERNICK: Could we show GG-2125?

23 Q And I'll ask you to simply go through with the Court how
24 this slide frames the issue that you've addressed.

25 A What the essential question is, I believe, is whether or

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1 not asbestos exposure alone increases one's risk for developing
2 lung cancer, so in the absence of asbestosis. And then the
3 second part of that analysis is whether or not asbestosis is a
4 necessary prerequisite to attribute asbestos exposure or lung
5 cancer to asbestos exposure.

6 Q Okay. Are there studies that have been done -- research
7 that has been done that bears upon that question? That is
8 whether asbestos exposure alone without asbestosis causes lung
9 cancer?

10 A Yes.

11 Q Showing you 2126, does this provide a list of the kinds of
12 studies that you've examined that relate to this question?

13 A Yes.

14 Q Could you just explain to the Court the difference between
15 these studies and whether there are any differences in the
16 quality of -- let me take that back. Whether some of the
17 studies are better and some of the studies are less good in
18 terms of speaking to the particular issue that you are here to
19 address?

20 A Yeah, there are varying levels of evidence around this
21 question, as you might imagine, and even within these
22 categories there's different levels of evidence. Some of the
23 scientific literature, even say in the longitudinal area, are
24 better than others.

25 Q Okay. Let's just go through what's the difference between

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1 the longitudinal study and the case control study?

2 A A longitudinal study is defined by an exposed cohort, and
3 that cohort is followed prospectively, and causal relationships
4 are then ascertained by following that cohort for a number of
5 years.

6 Q Okay. What about case control? Doesn't case control
7 involve cohorts?

8 A It does, and the co --

9 Q So what's the difference then?

10 A There is a difference in that the case control, as the
11 name implies, is defined by having a disease itself rather than
12 necessarily having an exposure itself.

13 Q Okay. What about time sequence? In case control studies
14 do you have the ability to follow a group over time?

15 A You don't, because the case itself is defining the cohort,
16 and so what you're left with is actually looking at the disease
17 that you're interested in studying, and sometimes looking
18 backwards to determine causal relationships, for instance.

19 Q So it's like you begin at the end of the line with people
20 who are sick, and then working with that group you look to
21 antecedents?

22 A Correct.

23 Q Okay, or you look to factors?

24 A That's right.

25 Q Okay. What about the autopsy studies? What are -- what

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1 do they involve, and why are they different from longitudinal
2 and case control studies?

3 A Autopsy studies are studies that have lung tissue as its
4 very basis. So they look at patients that have passed away,
5 lung tissue is examined, and causal relationships are attempted
6 to be determined by looking at that lung tissue and then
7 finding out more about the patients that passed away.

8 Q Okay. Now with respect to the longitudinal studies, let
9 me just ask you, how do these different kinds of studies stack
10 up in terms of which ones are, you know, more useful and more
11 productive to examine in order to address your questions, case
12 control, longitudinal, or autopsy?

13 A Generally speaking, the longitudinal studies are the best,
14 although their quality varies within that subgroup. But,
15 generally speaking, longitudinal studies are the best.

16 Q Are there a lot of longitudinal groups that have been
17 examined over time that relate to this issue?

18 A Unfortunately not. They're very difficult to perform
19 because of their time course, how long it takes to get to the
20 answer, and very few research units are able to look at these
21 factors over a period of time and collect data on the cohort.

22 Q Turning your attention to Slide GG-2127, what does this
23 slide now do with respect to the issue that you've addressed
24 here?

25 A So in terms of the attribution of lung cancer, I've put on

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1 this slide longitudinal studies, case control studies, and
2 autopsy studies that I think address this issue.

3 Q Okay, and then what you have is 1 and 2. What are the
4 columns? What do they refer to?

5 A They refer to the initial question that I framed, the two
6 groups of thought regarding attribution of lung cancer to
7 asbestos. Is asbestos exposure alone that's necessary, or is
8 it the presence of asbestosis?

9 Q Okay. Let's begin with the insulator studies. How far
10 back do the insulator -- does the insulator group go in terms
11 of the group that was being studied?

12 A Dr. Selikoff at the Mt. Sinai Group really developed this
13 cohort in the 1960s and followed it for a number of years
14 afterwards.

15 Q Okay. Now, you have under the question, "Does asbestosis
16 cause lung cancer? Yes, but do the -- does asbestos exposure
17 alone cause lung cancer, question mark." Could you explain to
18 the Court what you were able to learn and what you were not
19 able to learn from the insulator studies.

20 A When you look at Dr. Selikoff's insulator studies, you do
21 see an increased rate of lung cancer. However, what's
22 important about those studies is that he was not able to ferret
23 out who was just asbestos exposed alone versus who had
24 asbestosis.

25 Q And why was that?

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1 A He did make that effort initially with a cohort to make
2 that distinction.

3 Q Okay. In other words, would it be fair to say -- was the
4 study originally designed -- was the insulator study originally
5 designed to address the specific issue that was of interest to
6 you?

7 A No, it was not.

8 Q Okay, and what in particular was missing from the design
9 that would've enabled that study to speak more directly to the
10 issue that you were interested in?

11 A It was the lack of information regarding who has
12 asbestosis, the parenchymal lung disease, and who is just
13 asbestos exposed.

14 Q Why then did you fill in the column under 2, "Does
15 asbestosis cause lung cancer? Yes?"

16 A If you follow Dr. Selikoff's work -- now we're up into the
17 late eighties -- there were publications coming out of that
18 group that tried to answer that question specifically in whom
19 radiographic and pathologic evidence was available.

20 Q Okay, and what did that evidence tend to show?

21 A The evidence showed that in 100 percent of the cases where
22 lung tissue was available, 100 percent of the lung cancer cases
23 had asbestosis by lung tissue.

24 Q Okay. Let's turn to the second study that you have or the
25 second group, the asbestos cement studies. Could you describe,

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1 first of all, who performed those studies and when they were
2 performed?

3 A This was performed -- this study was performed by a group
4 of researchers at Tulane University beginning following the
5 cohort in the late sixties and following the cohort really
6 through their publication in the early 1990s.

7 Q Now, Tulane sounds familiar.

8 A Yes.

9 Q That's where you went to school?

10 A It is.

11 Q One of the authors also has a familiar name, Weill.

12 A Yes.

13 Q Is there any relation?

14 A He's my father.

15 Q Okay, so if you could describe for us the workers who were
16 studied in this Tulane study, who were they?

17 A They were a group of asbestos workers, 839 workers, who
18 had mixed asbestos exposure, meaning some to chrysotile-type
19 fibers and some to amphibole-type fibers.

20 Q Okay, and then what happened during the course of the
21 study? What did the study comprise?

22 A The researchers were able to prospectively follow this
23 group in a longitudinal fashion where they had well-defined
24 exposure categories and radiographic information.

25 Q Okay, and now you have the columns -- both columns filled

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1 out in this case. Under the column dealing with, "Does
2 asbestosis cause lung cancer," you have a yes, and now you've
3 also filled in the first column, "Does asbestos exposure cause
4 lung cancer," and you have it filled in no. What was different
5 -- what, if anything, was different about this group in this
6 study that enabled you to answer the first question whereas the
7 insulator studies did not permit you to answer that question?

8 A Because the insulator studies were never set up that way,
9 they were never able to answer the first question. The
10 asbestos cement studies were specifically set up to answer that
11 question, is asbestosis a necessary prerequisite for lung
12 cancer development.

13 Q Okay. Are there a couple slides that would help you walk
14 through the actual data from those studies, give two slides
15 that have been prepared here?

16 A Yes.

17 Q Okay. Showing you, first of all, 2129 -- that is GG-2129
18 -- could you describe for the Court -- first of all, is this
19 slide -- the data here, is it taken directly from the published
20 article itself?

21 A Yes, it is.

22 MR. BERNICK: Okay. And, incidentally, the published
23 article, Your Honor, for the record is Exhibit 590. That is
24 GX-0590. We won't be offering it, because it's a learned
25 treatise, and it comes in in support of his opinion. But, for

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1 the record, this demonstrative --

2 Q Is it correct, this demonstrative is based upon the
3 article?

4 A Yes.

5 Q Okay. What is it that 2129 -- that is GG-2129 shows the
6 Court?

7 A So on the horizontal axis of this graph there's cumulative
8 exposure in fiber years. So that's a way that researchers,
9 when they're doing epidemiologic studies, can quantitate the
10 asbestos exposure.

11 Q Okay. What then would the data points that you have as
12 displayed in this graph tell you about the relationship between
13 exposure in fiber years and the relative risk for lung cancer?

14 A So what it can tell you is that as the exposure --
15 cumulative exposure dose goes up, the risk of developing lung
16 cancer increases as well.

17 Q Okay. Is that a continuous relationship down to zero?

18 A No, it's not.

19 Q Well, then tell us what is it that happens when you get
20 down to lower exposures?

21 A The shape of the relationship or the shape of the curve
22 becomes uncertain at the lower exposure levels.

23 Q Okay. Well, there's been discussion in connection with
24 the opening statements in this case regarding threshold models.
25 Actually, also in connection with the testimony that was

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1 offered by Dr. Rodricks last week. Do you have an
2 understanding of about what a threshold model is?

3 A Yes.

4 Q Okay. Could you just explain to the Court what a
5 threshold model is?

6 A A threshold in epidemiologic and occupational medicine is
7 the concept that a certain level of exposure is necessary to
8 attribute risk of developing whatever disease you're interested
9 in.

10 Q Okay. In where you have the threshold, do you -- are you
11 able to see increased risk all the way down to small exposures?

12 A You're not, because you're not certain, as this slide
13 indicates, of the dose response relationship, i.e., what dose
14 gives you what response.

15 Q Okay.

16 A And you're uncertain at these lower exposure levels what
17 that response is.

18 Q Okay. Now, based upon this data -- that is that at higher
19 exposures there was an increased risk of lung cancer --
20 wouldn't that tend to suggest higher does lung cancer? Going
21 back to your question, yes, there is a relationship between
22 asbestos exposure alone and lung cancer.

23 A The researchers looked at that issue --

24 Q Okay.

25 A -- and what they found is is that it wasn't a distinction

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1 between dose that really mattered. In other words, it wasn't
2 that every single increasing dose increased your risk for
3 developing cancer. Instead, what they found is that the dose
4 was not the distinguishing factor. The presence of
5 radiographic asbestosis was when we look at lung cancer risk.

6 Q Turning your attention to Slide 2128, is this a further
7 slide that was taken from the Hughes and Weill study?

8 A Yes.

9 Q And what does this slide show, and how does it relate to
10 what you just said?

11 A On the vertical axis again it's looking at risk and
12 standardized mortality rates, and on the horizontal axis,
13 you're looking at various abnormalities of x-rays. So various
14 profusion categories, to use the ILO lingo.

15 Q Okay, so if we go from the left to the right, we have the
16 first data area. It says, "No abnormal less than 21 years."
17 What does that mean?

18 A So there were no chest radiographic abnormalities in that
19 group, and these were people that worked less than 21 years --

20 Q Okay.

21 A -- in the cement industry.

22 Q And did they have an increased risk of lung cancer?

23 A No.

24 Q Let's now talk about the people who worked for a long
25 time. Would that mean that they have higher or lower

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1 exposures?

2 A Higher.

3 Q Because the people that have higher exposures but who also
4 did not have radiographic abnormalities, is that the second
5 data point?

6 A Yes.

7 Q And what was found with respect to them? Did the people
8 with higher exposures but no abnormalities, did they or did
9 they not have an increased risk of lung cancer?

10 A No increased risk in that group.

11 Q What about pleural? That is people who have pleural
12 abnormalities. First of all, are those people who have the
13 opacities in the meat of the lung that we were talking about,
14 or they are the ones who have a condition in the pleura?

15 A Abnormalities of the pleura.

16 Q Okay. Was that found to be tied to lung cancer risk?

17 A No.

18 Q Now, we have small opacities. What are we referring to
19 now?

20 A In this instance we're referring to patients who have --
21 again to use the ILO lingo -- a zero slash one chest
22 radiograph.

23 Q Okay. Zero slash one, we're going to get to that, but is
24 that a strong indicator of there being opacities?

25 A No, everyone really considers that a normal film.

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1 Q Okay. Now, once we get to the people who have small
2 opacities with the one slash zero plus, who are those people?
3 That is what are we getting at when there's a reference to
4 small opacities with a one slash zero plus?

5 A So those people clearly have radiographic evidence of
6 asbestosis.

7 Q Okay, and with respect to the people who have radiographic
8 asbestosis -- evidence of asbestosis, what, if any, observation
9 did you make as to whether that was related to an increased
10 risk of lung cancer?

11 A The researchers found that it did increase the lung cancer
12 risk over four times.

13 Q Okay. Showing you then Slide 2130 -- GC-2130, is there --
14 together with the statistical evidence, tell us whether there
15 is any theory -- mechanistic theory that would draw a
16 relationship between lung fibrosis and lung cancer.

17 A Researchers have been interested in the fibrosis question
18 from a biochemical standpoint for some time, greater than 20
19 years. The slide here really depicts a plausible hypothesis
20 for how lung cancer has as its prerequisite fibrosis, and I can
21 walk through the slide, if you'd like.

22 Q Yeah, just -- if you'd just do that. Spare us I guess. A
23 little bit briefly. It's here in the morning --

24 A I understand.

25 Q -- and I'm very confident that Dr. Mullady over there will

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1 have detailed questions on this part of your examination.

2 A Anybody that wants more information can see me afterwards.

3 Q Okay.

4 A The stimulus in this case is asbestos, and so what
5 asbestos does, as the slide depicts, is cause an inflammatory
6 process in the lung. Most inflammatory processes, whatever
7 they're caused by, can be repaired in the lung, and that's why
8 every exposure and everything that happens to us doesn't cause
9 disease. But what can happen when the defense strategies are
10 overwhelmed, these inflammatory processes can get unchecked and
11 out of control, and various mediators, including things like
12 growth factors and cytokines that I won't bore you with, cause
13 a lung injury pattern, and they have -- and fibrosis and lung
14 cancer have these mediators in common. And so when we look at
15 the epidemiologic evidence, we're looking at the causal
16 association, which I think makes sense, but then this develops
17 the why part. Why is lung cancer attribution -- why is
18 asbestosis a necessary prerequisite? And I think what you get
19 from this model is a biologically plausible explanation that
20 they're common mediators that lead to both diseases.

21 Q Okay. Now is there anything else in the literature in
22 other areas besides asbestosis that would be consistent with
23 the model for fibrosis-related cancer that you've just
24 described?

25 A Yes, there are.

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1 Q Okay. Showing you 21 -- GG-2131, does this slide again
2 provide a list of those areas of research?

3 A Yes, it does.

4 Q Okay. Can you just explain those entries briefly?

5 A The literature on fibrotic lung disease has as one of its
6 components the concept that diffuse fibrosis of other causes
7 apart from asbestos exposure like idiopathic pulmonary
8 fibrosis, scleroderma, or sarcoidosis. All are associated with
9 an elevated cancer risk. And I think this was initially shown
10 probably most elegantly by Dr. Turner-Warwick and her group in
11 London 1980 when she looked at the cryptogenic fibrosing
12 alveolitis group, which in America we call IPF, idiopathic
13 pulmonary fibrosis. And she found a fourteenfold increase in
14 lung cancer rates in those patients that had that condition.

15 Q Okay, and what about Weill and McDonald? Did they -- did
16 that paper also bear upon this?

17 A It did. It looked at an occupational-exposed group in
18 this case, workers that had silicosis, and their opinion was
19 that also -- the presence of silicosis increased the cancer
20 risk.

21 Q Okay. Turning back to our original question, Dr. Weill,
22 and Slide 2132, how do you ultimately answer the question about
23 whether asbestos exposure alone without asbestosis causes lung
24 cancer?

25 A So based on what we've talked about so far, I've been able

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1 to conclude from my review of the literature and my
2 understanding of it, that asbestos exposure alone does not
3 increase the risk of developing lung cancer.

4 Q Are you aware of any reliable scientific work that
5 specifically addresses this issue that is exposure alone versus
6 asbestosis -- and I want to focus on this -- produces reliable
7 data that is specific to this issue -- specific to this issue
8 which shows the contrary? That is it's not asbestosis. It's
9 asbestos exposure alone.

10 A No.

11 Q Are there other authors -- other authors of papers who
12 have expressed opinions on this subject that are consistent
13 with your own?

14 A Yes.

15 Q Showing you GG-2138, is this a list of some of the other
16 papers that reflect opinions that are consistent with your own?

17 A Yes, it is.

18 Q Now, I want to turn from the conclusion that you've
19 express to talking about a couple of other related issues.
20 First of all, have you or have you not considered the concept
21 of synergy as applied to this issue?

22 A I have considered that.

23 Q Okay, and do you have a slide that illustrates the concept
24 of synergy?

25 A Yes.

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1 Q Showing you GG-2133, could you explain what 2133
2 delineates and why that would be relevant to the question of
3 whether asbestos alone can cause lung cancer -- asbestos
4 exposure alone can cause lung cancer?

5 A This slide again depicts what was concluded from the
6 Selikoff insulator studies, and if you look at the left side of
7 the slide, it looks at the relationship between asbestos
8 exposure alone and cigarette smoking. And Selikoff and his
9 group concluded that those two factors work synergistically to
10 increase the risk of lung cancer.

11 Q Okay. If that is true, that is if the synergy is between
12 asbestos exposure alone and smoking, what relationship, if any,
13 would that -- have that -- would that bear to your basis
14 question, which is whether asbestos exposure alone can cause
15 lung cancer?

16 A It doesn't really answer that question, because again it
17 doesn't ferret out the patients or identify the patients
18 specifically who have reliable evidence of asbestos.

19 Q Is there a slide, showing you GG-2134, which talks about
20 whether the Selikoff insulator studies support the idea that
21 asbestos exposure alone together with smoking but absent
22 asbestosis, whether that can cause lung cancer?

23 A There is not an ability from the information in the
24 insulator studies to examine that specific question, and so, in
25 my opinion, they were not able to make the synergistic

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1 relationship that this slide depicts.

2 Q Okay. Now again is that the same kind of limitation that
3 you described before as the limitation on being able to tease
4 out the asbestotics from the people who were simply exposed to
5 high levels?

6 A That's right.

7 Q Okay. Likewise, going through to Slide 2135, when it came
8 to the Hughes-Weill study, did the Hughes-Weill study provide
9 specific information on this issue?

10 A It did.

11 Q And could you, using 2135, explain to the Court what
12 specific information was supplied by the Hughes-Weill study and
13 how it bore upon the question of whether -- of what the synergy
14 was?

15 A So since all of the lung cancers in the asbestos cement
16 cohort existed in smokers, and the risk of developing lung
17 cancer due to asbestos exposure was confined to the
18 asbestotics, a synergistic relationship was able to be
19 demonstrated not between asbestos exposure alone in cigarette
20 smoking but instead asbestosis and cigarette smoking.

21 Q Okay, and has that been illustrated in Slide GG-2136?

22 A Yes, it is.

23 Q Okay. Now, the synergistic relationship between smoking
24 and asbestosis, would that or would that not be consistent with
25 the biological mechanism that you described to the Court?

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1 A It is consistent.

2 Q Okay. There's been reference here in this case to the
3 Helsinki criteria. Are you familiar with the Helsinki
4 criteria?

5 A Yes, I am.

6 Q And have you considered the Helsinki criteria when it
7 comes to addressing the question of whether asbestos alone is
8 causally -- asbestos exposure alone is causally related to lung
9 cancer?

10 A I have.

11 Q And what consideration have you given to it?

12 A The Helsinki criteria, as it's stated, is a consensus
13 opinion among people working in the field about, among other
14 things, the lung cancer/asbestos story.

15 Q Okay, and what weight do you give that in your assessment
16 of the actual epidemiological data?

17 A It's not an epidemiologic study itself. It's an opinion
18 piece of people that have worked in the field came together to
19 discuss these issues.

20 Q Okay. Have you looked to see what some of the purposes
21 were that drove this consensus effort?

22 A Yes.

23 Q Showing you Slide 2137, does that reflect whether or not
24 compensation was one of the factors that was a goal in
25 connection with the Helsinki criteria?

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1 A Yes, it was.

2 MR. FINCH: Objection. Lack of foundation. He
3 wasn't a member of the Helsinki criteria. He doesn't know what
4 was in the -- this is a snippet of a multi-hundred-page
5 document. The summary is a ten-page document. I don't believe
6 he has the foundation to explain to the Court what was the goal
7 of the Helsinki.

8 MR. BERNICK: Well --

9 THE COURT: Mr. Bernick.

10 MR. BERNICK: -- it's very simple. I --

11 BY MR. BERNICK:

12 Q Does this come from the Helsinki document?

13 A Yes.

14 Q Okay, and do the words say appropriate compensation?

15 A Yes, they do.

16 Q Are they the basis for the assessment that you made based
17 upon your expertise regarding what assessment or what weight to
18 give to the Helsinki criteria?

19 A Yes.

20 MR. BERNICK: Okay.

21 THE COURT: All right. Just a second. Let me read
22 it.

23 (Pause)

24 THE COURT: All right. This is the type of
25 information that an expert in his field would consider in

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1 issuing an opinion. So although the question as stated I agree
2 was objectionable, I believe at this point Mr. Bernick has
3 cured that objection by asking whether or not now this
4 information serves as a basis for this expert's opinion, and
5 now that objection has been cured. Okay.

6 MR. BERNICK: Thank you.

7 BY MR. BERNICK:

8 Q Now, I want to turn a little bit now to talking about
9 making the transition from what you've told us about the
10 relationship between asbestosis and lung cancer and the work
11 that has been done specifically in connection with this
12 estimation. And I want to go back to -- let me just ask you a
13 general introductory question. Are there published criteria
14 for the diagnosis of asbestosis?

15 A Yes, there are.

16 Q Okay. Who has published -- what group has published
17 criteria with respect to the diagnosis of asbestosis?

18 A Primarily, the American Thoracic Society.

19 Q Have you examined the history of the American Thoracic
20 Society publications to determine whether or not there has been
21 any change or evolution in those criteria?

22 A I have.

23 MR. BERNICK: Okay. Your Honor, at this point we
24 would offer GX-0280 and 0274.

25 THE COURT: Wait. I'm sorry. What are you offering?

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1 MR. BERNICK: Well, I -- I'll tell you we'll do it
2 the old-fashioned way. I'm sorry. These are in the binders.
3 They are GX-0280 and GX-0274. And may I approach the witness?

4 THE COURT: Yes.

5 (Pause)

6 Q Are you familiar with those documents, Dr. Weill?

7 A Yes, these are the ATS statements.

8 Q Okay, and is Exhibit GX-0280 the 1986 statement, and is
9 GX-0274 the December 12, 2003 statement?

10 A Yes.

11 Q And are these recognized statements within the field of
12 pulmonary medicine?

13 A Yes.

14 MR. BERNICK: We would offer them, Your Honor.

15 MR. FINCH: No objection, Your Honor. I think there
16 is duplicative exhibit labeling. I mean the ACC and FCR have
17 also identified these as exhibits, so at an appropriate time
18 we'll give you the ACC and FCR number that is the same
19 document. We have no objection to the admissibility of either
20 document.

21 MR. MULLADY: No objection.

22 THE COURT: All right. GX-0280 and GX-0274 are
23 admitted.

24 MR. BERNICK: Okay.

25 BY MR. BERNICK:

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1 Q Now has there been any change in the diagnostic criteria
2 for asbestosis reflected in these documents? That is from the
3 eighties until more current times.

4 A There have been.

5 Q Okay. Could you just describe to the Court what has
6 happened to the diagnostic criteria for asbestosis that is of
7 relevance to your testimony here?

8 A Some of the components are similar, but probably the most
9 distinct difference is with regards to the degree of
10 radiographic abnormality that each statement supports.

11 MR. BERNICK: Okay. I want to approach, if I can?
12 Do we have a marker? And I'll just slide this over here. Is
13 this all right, Your Honor?

14 THE COURT: Yes.

15 MR. BERNICK: Thank you.

16 Q B-readers read what?

17 A Radiographic -- x-rays from people that are exposed to
18 various dust-related diseases.

19 Q Is there a classification or rating system that the B-
20 readers use in doing their evaluation?

21 A There is.

22 MR. BERNICK: Can we -- you know what you might do is
23 just -- do you have a clip -- a big clip? I think if you put
24 it down further it might be a little bit easier, or not? Okay.
25 Okay. No. Well, I'll just hold onto it. Okay.

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1 Q The B-readers when they're doing x-rays, do they have a
2 rating system?

3 A Yes.

4 Q And what's the -- does it -- is it comprised basically of
5 two numbers with a slash in between?

6 A Yes, but in terms of the profusion category, the
7 parenchymal abnormalities, yes.

8 Q When it comes to parenchymal, we're now again in the meat
9 of the lung --

10 A Right.

11 Q -- and we're looking for abnormalities.

12 A Correct.

13 Q Okay, and you've made reference to opacities. Is that
14 what we're looking for?

15 A Yes.

16 Q Okay, so we're looking at the x-ray, and we're saying do
17 we see opacities or not.

18 A That's right.

19 Q And is this a system that's designed to rate the degree to
20 which opacities are being found?

21 A Yes.

22 Q What's -- what are the numbers that -- what's the range of
23 numbers?

24 A So there's 12 categories from zero slash zero all the way
25 to three slash three --

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1 Q Okay.

2 A -- with all the steps along the way.

3 Q And the higher the number means more opacities.

4 A That's right.

5 Q What does the first number refer to versus the second
6 number?

7 A The first number is to indicate what the reader has the
8 most confidence in in terms of the profusion category.

9 Q Okay. Now, under the ATS standards -- the earlier ATS
10 standards, was there or was there not a guidance or a
11 recommendation about the minimum finding of opacities that
12 would support a diagnosis of asbestosis?

13 A There was.

14 Q Okay, and what was it?

15 A One slash one.

16 Q Which means?

17 A That the reader first considered the x-ray abnormal to the
18 degree of one, and that he did not or she did not consider any
19 other profusion category.

20 Q Okay. What was the change? As we went forward with the
21 diagnostic criteria as recommended by the ATS, what changed?

22 A The 2004 statement indicates that a profusion category of
23 one slash zero is sufficient to make the diagnosis.

24 Q And that would be -- mean what?

25 A That the reader had the most confidence in a profusion

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1 category of one, would also consider that the x-ray was normal,
2 i.e., a profusion category of zero.

3 Q Okay. Now, I want to ask you a question that's very, very
4 specific here. Is there any -- is the category -- there's only
5 one -- two lower categories, right, the zero slash one and the
6 zero slash zero.

7 A Right.

8 Q Are either of those categories or ratings considered to be
9 abnormal?

10 A No, they're normal.

11 Q Okay, so am I correct that under the new standard any
12 reliable B read which finds any changes in the parenchyma
13 equals asbestosis today?

14 A That's right.

15 Q So as long as there's any reliable radiographic evidence
16 showing changes of the parenchyma, bingo, asbestosis?

17 A That's right.

18 Q Okay. I guess it doesn't really matter that much anymore.
19 Let's go back to GG-2139 and spend a minute walking through
20 what 2139 illustrates. We have your same old icons. We have
21 asbestos exposure alone. We have asbestosis, which you say has
22 been tied to lung cancer. That's the yes. But it then says --
23 it then has asbestosis kind of growing as a category, and it
24 says today includes reliable radiographic evidence of any
25 asbestosis-related parenchymal lung change. Is that or is that

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1 not accurate?

2 A Yes, it is.

3 Q And given what the -- what's happened to the diagnostic
4 recommendations of the ATS, when you talk about asbestosis, are
5 you talking about a smaller group than was true historically,
6 the same group, or a broader group?

7 A Likely a broader.

8 Q Thank you. In light of that, today does, quote,
9 asbestosis exclude anybody who has reliable radiographic
10 evidence of any parenchymal lung change?

11 A Yes, it does.

12 Q Who does it exclude?

13 A It excludes anybody with a normal chest radiograph.

14 Q Okay, so I think I've probably -- you didn't hear my
15 question or answer it the right way. Does the diagnosis of
16 asbestosis exclude anybody with reliable radiographic evidence
17 that they do have a lung change?

18 A No, it doesn't include anybody.

19 Q Okay. Let's turn then to the Henry study. Are you
20 familiar with the Henry study?

21 MR. BERNICK: And for the record, the Henry study,
22 Your Honor, is comprised with -- by a series of exhibits.
23 They'll be offered in through Dr. Henry. They are GX-284, 285,
24 286, 317 --

25 THE COURT: I'm sorry, Mr. Bernick, you're going too

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1 fast for me.

2 MR. BERNICK: I'm sorry.

3 THE COURT: Could you start the numbers again?

4 MR. BERNICK: Yes, it's -- Henry is GX -- let me do
5 them in order, 104, 284, 285, 286, 317, and 582.

6 MR. FINCH: Are you offering them now?

7 MR. BERNICK: No, they'll be offered through Dr.
8 Henry.

9 THE CLERK: Mr. Finch, please find a microphone.

10 MR. FINCH: Sure. My question is was he offering
11 them now. And since he's not offering them now, I don't have
12 any basis to object now.

13 MR. BERNICK: Okay. Did you -- do you want me --

14 THE COURT: I will ask something. May I ask a
15 question, because I think I got off on a track somewhere, and
16 I've gone -- I got confused. Doctor, do I understand your
17 testimony that the parenchymal changes can only be caused by an
18 exposure to dust -- to some dust product?

19 THE WITNESS: If we're talking about the disease
20 asbestosis, yes. Fibrotic lung conditions can happen due to a
21 variety of reasons. There's over 150 causes.

22 THE COURT: Okay, but you're testimony today is
23 related only to asbestos exposures. Correct?

24 THE WITNESS: Yes.

25 THE COURT: So your testimony with respect to the

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1 Thoracic -- American Thoracic Society changes is specific to
2 exposures to asbestos?

3 THE WITNESS: Yes.

4 THE COURT: Okay. Thank you.

5 BY MR. BERNICK:

6 Q And again, to be clear, so long as there is any reliable
7 evidence on B read that there's any change whatsoever to the
8 parenchyma, that would be -- that would support a diagnosis of
9 asbestosis.

10 A That's correct.

11 Q Okay. Now, presumably, the diagnosing doctor would also
12 have to be told if the individual has worked with asbestos.

13 A That's right.

14 MR. BERNICK: Okay.

15 THE COURT: Yes, that was my confusion, because I was
16 slinking -- I was missing the link between the diagnostic
17 change and I guess the work history.

18 MR. BERNICK: Yeah.

19 THE COURT: Okay.

20 BY MR. BERNICK:

21 Q And this is a very important point, so that -- you have a
22 one slash zero, and there was a day -- in the earlier
23 asbestosis one one smaller group. There?

24 A Yes.

25 Q We then have people who have one slash zero today, larger

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1 group, and then we have people who have no -- have one slash
2 zero but no asbestos exposure. They don't say that they're
3 exposed to asbestos. Is your testimony that provided somebody
4 -- a patient comes in and says I worked with asbestos, so long
5 as they have this -- any evidence -- reliable evidence of any
6 change to the parenchyma on examination of x-ray therein?

7 A Yes.

8 Q Now did Dr. Henry study people who had submitted x-rays in
9 B reads in this case?

10 A Yes.

11 MR. FINCH: Objection. Relevance. May I state the
12 basis of --

13 THE CLERK: You have to use a microphone.

14 MR. FINCH: Sure. May I state the basis of the
15 relevance objection, Your Honor?

16 THE COURT: Yes, but before you go into this -- I'm
17 sorry. My mind is still a little bit behind you folks, so
18 before you get into this I'd still like to follow up with where
19 I am. Is this a presumption, Doctor, that the one slash zero
20 with the asbestos exposure is presumed to have asbestosis, or
21 is it simply taken as a statement of fact that if you have one
22 slash zero, you have asbestosis if you also had exposure to
23 asbestos?

24 THE WITNESS: If you have one slash zero or above,
25 profusion category in the presence of an exposure that the

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1 physician thinks elevates the risk of developing asbestosis,
2 then you've got the diagnosis.

3 THE COURT: So there is a value judgment by the
4 physician that has to be added to this component.

5 THE WITNESS: Absolutely.

6 BY MR. BERNICK:

7 Q But is -- let me just -- and we're going to pursue that,
8 Your Honor, in detail when we get to -- is what the Court just
9 asked you about, Dr. Weill, an issue of differential diagnosis?

10 A Right.

11 Q Okay, so we have a one slash zero. Is it fair to say that
12 the one slash zero could be due to asbestos but also could be
13 due to something that's not asbestos.

14 A Yes.

15 Q And a doctor doing a differential diagnosis, finds the one
16 slash zero, has to inquire about exposure.

17 A That's right.

18 Q Tell the Court whether or not there is variability in the
19 quality -- in the quality of information that a doctor can get
20 about exposure.

21 A There's a wide variety in the quality of the information.
22 Some of the information comes from the patient himself, of
23 course, and that can vary from patient to patient. Some of the
24 information comes from the epidemiologic studies that address
25 the exposures in a specific occupation, and that information

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1 has to be considered strongly as well, because it gives you a
2 background for what that patient might have been exposed to.

3 Q Okay. Do you -- does a doctor necessarily have enough
4 information about exposure to compare that patient to the epi
5 studies?

6 A No, often not.

7 Q Now, let's get back to -- we're going to talk -- are we
8 talking a bit more about this as we get towards the end?

9 A Yes.

10 Q Okay, but when it comes -- and I think t his is the --
11 maybe I should've been clearer. When it comes to the
12 radiograph itself, is the radiograph -- is the radiograph -- if
13 it's one plus zero or greater, does the radiograph exclude
14 anybody who's got any reliable evidence of changes in the
15 parenchyma?

16 A No, it doesn't.

17 Q Okay, so might there be exclusion based upon exposure
18 history?

19 A Yes.

20 Q Okay, but in terms of the radiograph itself, if you have
21 evidence of any change there in the parenchyma from the point
22 of view of that diagnostic tool, you're in?

23 A Yes.

24 MR. BERNICK: Okay. Is that -- I don't know if
25 that --

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1 THE COURT: Yes, that helps. Thank you.

2 THE WITNESS: It's a very objective piece of
3 evidence.

4 MR. BERNICK: Right.

5 THE COURT: That helps. Thank you.

6 MR. BERNICK: Okay.

7 BY MR. BERNICK:

8 Q Now, let's talk about Dr. Henry's study. Did Dr. Henry's
9 study look to see who within the group that he sampled had
10 asbestosis by radiograph and who did not?

11 A Yes, he did.

12 MR. FINCH: Objection. Relevance. And I think this
13 may be an appropriate time to either take a sidebar or excuse
14 the witness. I think I can state the basis of the objection
15 rather succinctly, but I don't want to influence the witness'
16 testimony or to have any debate of this matter in the presence
17 of the witness, so would --

18 MR. BERNICK: Well, whatever --

19 MR. FINCH: -- Your Honor --

20 MR. BERNICK: I don't care. I mean --

21 THE COURT: All right. Doctor, I'm going to ask you
22 to take a very short five-minute recess, if you wouldn't mind,
23 sir, please?

24 MR. BERNICK: This is on your time now. Right?

25 MR. FINCH: This is on my time, Mr. Bernick. Start

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1 the stop watch right now.

2 THE COURT: Just a minute.

3 (Pause)

4 THE COURT: All right, Mr. Finch.

5 MR. FINCH: The ACC objects to the introduction into
6 evidence of any or all of the questionnaires, proof of claim
7 forms, x-ray materials, and any analysis or testimony based
8 upon them on relevance grounds, and we have two substantive
9 reasons. First --

10 THE COURT: Those in this case?

11 MR. FINCH: First --

12 THE COURT: You object to the proofs of claim and the
13 PIQs in this case?

14 MR. FINCH: Your Honor, may I state the basis for the
15 objection?

16 THE COURT: Yes, please.

17 MR. FINCH: First, under the settled law of this
18 district, what is to be estimated here is the cost that Grace
19 would incur over time to resolve its asbestos personal injury
20 and death cases that are not resolved as of the petition -- the
21 time the bankruptcy petition was filed and which would
22 thereafter arise in the tort system going forward in the
23 future. That estimation, pursuant to the same settled case law
24 -- and by that I'm referring to Owens-Corning and Armstrong,
25 Eagle Picher and Federal-Mogul -- is to be based on the cost

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1 which Grace bore to resolve thousands of similar cases prior to
2 the petition date subject to modification to reflect any
3 obvious changes that have happened in the tort law -- in the
4 tort system. If we are correct that this is the law, and if we
5 are correct that this is the method by which the Court must
6 estimate that liability, those costs, then the material in the
7 files of the unsettled claimants, the people who were -- had
8 claims that hadn't been settled as of the time Grace went into
9 bankruptcy developed and maintained in their files after the
10 petition date, has not relevance, since the evidence for the
11 cost of the liability is found in Grace's history of tens of
12 thousands of already resolved cases and not in the various
13 materials in the process of development in the unsettled cases.

14 We have a second basis for our relevance objection.
15 Even if, as the debtor argues, it is appropriate for the Court
16 to consider the so-called, quote, legal liability of claims
17 pending against Grace at the time the petition was filed, which
18 have not yet been settled or resolved, the material that may
19 have been collected from time to time in the files of the
20 claimants in a period during which litigation and prosecution
21 of their cases against Grace has been stayed is not relevant
22 proof of what would be developed by way of evidence by the same
23 claimants should their claims have actually proceeded to trial.
24 Indeed, there will be evidence that will be -- witnesses who
25 will testify to that very proposition.

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1 The Court should be well aware that no court has set
2 a trial date for the trial of any asbestos personal injury
3 claim for either trial by allowance or trial by jury. The
4 Court has never set a deadline to the -- require any personal
5 injury claimant to identify the testifying experts they would
6 rely on in trial, the industrial hygienists, the
7 epidemiologists, the toxic tort experts, in a case involving
8 Grace, nor could the Court do so under the estimation CMO,
9 since the August 29th, 2005 order that Your Honor entered
10 authorizing the estimation proceeding says it is a core
11 proceeding. And I'll remind the Court that under 28 USC
12 Section 157(b)(2) a core proceeding cannot be something that is
13 the allowance or disallowance of individual claims for purposes
14 of distribution.

15 Third, the questionnaire does not ask any personal
16 injury claimant to identify the expert and fact witnesses that
17 will testify in a trial involving their case, nor does it
18 require the claimants to identify every document or piece of
19 evidence that they would introduce into evidence in a trial
20 involving Grace. Therefore, whatever was in their file when
21 Grace served discovery on them, the interrogatories and the
22 document requests which are part of the questionnaire, and
23 that's what were produced in response to that, is what their
24 file showed at a moment in time in the bankruptcy and is not
25 evidence of what those very same claimants would prove in a

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1 trial involving Grace. It would be as if that at the beginning
2 of the case we had served document requests and interrogatories
3 on W.R. Grace on April 2nd, 2001 and said produce what you have
4 to prove your estimation case when they haven't hired all the
5 experts they're going to be parading in front of you.

6 THE COURT: They wouldn't be proving an estimation
7 case.

8 MR. FINCH: They are arguing about the methodology
9 and the proof. Your Honor, the point is it's an objection
10 based on lack of relevance for the grounds that I have stated,
11 and we would like a ruling on this to protect the record.

12 THE COURT: It's overruled. The evidence is clearly
13 relevant. With respect to the numbers of claims that the
14 debtor will have to reconcile pre-petition going forward, there
15 has been a bar date, and whether or not a claimant has
16 satisfied the proof of claim information and the PIQ was ruled
17 by this Court to be appropriate discovery in support of that
18 proof of claim. That, in fact, substantiates the proofs of
19 claim and the claims that, as of now, are the -- I'll call them
20 in quotes, and I do mean in quotes. I'm not making a ruling --
21 the allowed claim base upon which the debtor has to reconcile
22 what the present claims are and whether or not it will have a
23 future claims base based upon the claims base that it now knows
24 it has to face from its pre-petition past.

25 So in terms of numbers of claims, that is a relevant

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1 universe. This proof of claims database is it --

2 MR. FINCH: But this --

3 THE COURT: -- and if the claimant didn't file a
4 proof of claim against this estate, it's not going to be filed
5 in one against the trust.

6 MR. FINCH: The -- but the -- there's a difference
7 between filing a proof of claim --

8 THE COURT: Yes.

9 MR. FINCH: -- in the bankruptcy, but -- and what
10 Grace is seeking to do here, which is to argue that the
11 materials produced in discovery in response to the
12 questionnaire tells you anything at all about Grace's legal
13 liability for those individual cases.

14 THE COURT: I don't know what Grace is going to do
15 yet. You're objecting to relevance to the question did Dr.
16 Henry look to see who had asbestos or not. That's the
17 objection to relevance. I don't even know who Dr. Henry is
18 yet. There hasn't been any evidence as to who Dr. Henry is, so
19 this whole objection on the basis of this record as to
20 relevance at the moment, I have to overrule. I have no idea
21 why this question as to whether Dr. Henry, whoever he is, on
22 the basis of this record looked to see who had asbestosis or
23 not isn't relevant.

24 MR. FINCH: May I have a continuing objection on
25 relevance grounds to any analysis of the materials submitted

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1 pursuant to the questionnaires?

2 THE COURT: No, we don't even have -- I don't even
3 know what these documents are. They haven't been offered. I
4 haven't --

5 MR. FINCH: Okay, then we'll --

6 THE COURT: -- had them identified.

7 MR. FINCH: Then we'll take them up on a document-by-
8 document basis but --

9 THE COURT: We're going to have to until we get some
10 offer as to what the documents are, then I'll incorporate this
11 argument, Mr. Finch, and see where you want to go with it. But
12 in terms of relevance as to the proof of claim -- proofs of
13 claim in this case, they are highly relevant to set what the
14 current base upon which Grace's number of claims will be
15 estimated is.

16 Now, in terms of liability, we're not there yet. But
17 numbers of claims, they are very relevant, and the personal
18 injury questionnaire, that is discovery based upon those proofs
19 of claim, that has to have some relevant data. Whether it will
20 be relevant in the connection in which a particular question is
21 offered, I don't know. I can only examine that in light of the
22 evidence as it comes in.

23 MR. FINCH: Thank you, Your Honor.

24 MR. BERNICK: I do --

25 THE COURT: Why don't we all take a five-minute

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1 recess, and then we'll --

2 MR. BERNICK: Yes, what I --

3 THE COURT: I'm sorry.

4 MR. BERNICK: -- thought I would do while we're still
5 on the record -- I'm sorry, Your Honor -- is that I would
6 really -- I think I know what Mr. Finch is doing, which is that
7 he is making his record, and that's fine. He wants to make his
8 record on his objection. I would like to not have this
9 interfere with the witness continuing, so I would like to do is
10 to put squarely what the Henry study is. That it is a study
11 that, in fact, does relate to materials submitted in connection
12 with the PIQs, so that Your Honor can, I'm presuming, rule then
13 with respect to this witness' ability to testify about the
14 Henry study. And if -- at least we'll be done with that, so
15 that we don't have to go through this all as a hypothetical
16 exercise. So as soon as he comes back, I will elicit that
17 testimony, and then maybe if Mr. Finch wants to make an
18 objection, he can make an objection, and we can go on.

19 I'm really concerned -- I mean this is all I think
20 much more efficiently handled -- if he wants to make an
21 objection, we don't need their whole brief all over again. He
22 can simply say, well, you know, our position in this case is X,
23 Y, Z, Your Honor can rule, and we can get on with business.

24 MR. FINCH: That's my intention, Your Honor. I think
25 -- but I do have to protect the record, so that the District

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1 Court or whatever court's ultimately going to review this --

2 THE COURT: We protect the record at the appropriate
3 time not out of time, so that I can take it in the context.
4 When you make a relevance objection, I need it relevant to
5 something not to did Dr. Henry look to see whether or not there
6 was asbestosis. Mr. Mullady.

7 MR. MULLADY: Yes, Your Honor, just in the spirt of
8 Mr. Bernick's comment to keep the flow of the trial going and
9 not to have a continuous discussion about this, the FCR joins
10 the objection as stated by Mr. Finch on behalf of the ACC.
11 When the Henry evidence is admitted, we will simply object on
12 relevance grounds for the reasons Mr. Finch has articulated. I
13 will not reiterate those reasons unless the Court wants me to.

14 THE COURT: Well, with respect to the ACC and the
15 FCR, why don't I presume that if Mr. Mullady, you, or you, Mr.
16 Finch, or whoever trial counsel is for a particular witness,
17 makes an objection on behalf of either the ACC or the FCR, both
18 of you join in that objection, unless you tell me to the
19 contrary?

20 MR. MULLADY: That's fine, Your Honor.

21 THE COURT: Because your exhibits are joint, your
22 witnesses for the most part are joint.

23 MR. FINCH: That's fine, Your Honor.

24 THE COURT: Is that agreeable to both sides?

25 MR. MULLADY: That's acceptable.

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1 MR. FINCH: That's acceptable.

2 THE COURT: Fine. So I will assume that it is a
3 joint objection from now on unless you tell me to the contrary.
4 If you tell me to the contrary, then I will obviously not
5 assume that it is a joint objection.

6 MR. FINCH: Thank you, Your Honor.

7 MR. MULLADY: Thank you, Your Honor.

8 THE COURT: Now, Mr. Bernick, let's go back. All
9 right. The Henry study, tell me what your proffer is --

10 MR. BERNICK: Yes, the Henry study --

11 THE COURT: -- and let's do it by way of proffer.

12 MR. BERNICK: Yeah, the Henry -- that's fine. The
13 Henry study is, in fact -- Dr. Henry will testify next. He
14 took the x-rays that were submitted pursuant to the Court's
15 order, and he extracted a sample of those x-rays. These are x-
16 rays of people who have a claim for lung cancer. The world is
17 lung cancer claimants.

18 In this case we took the x-rays that those folks
19 provided. Dr. Henry took a sample of those x-rays and reviewed
20 those x-rays to determine whether the ILO standards, that is
21 how to have a reliable read -- and there's a standard that
22 deals with that -- to see whether they were met. That is could
23 you -- were these reads -- were these x-rays when read in
24 compliance with the standards, which requires, you know,
25 replicated readings, were they x-rays that properly showed a

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1 rating of one slash zero or greater. So Dr. Henry took the
2 recommendations of the ATS, applied them to this group, looked
3 for reliable B reads that met the one slash zero applying the
4 relevant ILO guidance on that question, and came up with the
5 result that in only seven percent of the lung cancer cases was
6 there a reliable that is replicable read of asbestosis defined
7 as the minimal criteria of one slash zero.

8 That seven percent was then used by Dr. Florence, and
9 it was used by Dr. Florence in two ways. He limited the
10 estimate -- that is the claims that would clear that threshold
11 -- to seven percent of the claims where those people -- where
12 the people had submitted an x-ray. Where they had not
13 submitted an x-ray, and they were supposed to -- that is they
14 had stated that -- that they were relying on the x-ray, those
15 were excluded. And where the claimant did not say that they
16 were relying on the x-ray but didn't have anything else that
17 they submitted by way of radiographic evidence, the same seven
18 percent was applied to that group on the theory that, well, if
19 they had submitted an x-ray, or maybe they had pathology, they
20 had committed to being relying on x-rays. So as a buffer seven
21 percent of those folks were allowed. So, essentially, the
22 seven percent figure coming out of the Henry study was used in
23 the estimation to draw a line between asbestosis claims that
24 were properly supported by reliable radiographic evidence and
25 ones that were not.

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1 THE COURT: Okay. Now you're objection now, Mr.
2 Finch.

3 MR. FINCH: With that proffer, I think the Court can
4 consider my objection in a framework that it's tied not only to
5 Dr. Henry but also to Tom Florence in the overall estimate.

6 My first objection -- the basis of the objection is
7 relevance, and, as I said before, there are two grounds.
8 Number one, we believe the controlling case law says you
9 estimate based on the history of resolving cases in the past.
10 It's clear that prior to the time that Grace went into
11 bankruptcy it did not require lung cancer claimants to
12 demonstrate a one slash zero x-ray to prove a case against
13 Grace.

14 Secondly -- and that the settlement rules that Grace
15 -- that Grace had placed as a cost in monetizing the claims'it
16 faced is the basis for what we think the Court has the ability
17 to estimate here.

18 But, secondly, even under Grace's theory, the
19 claimants have produced x-rays and other radiographic images,
20 which Grace hasn't reviewed in the Henry study in response to
21 the Court's order and Grace's discovery. That in no way means
22 that those claimants, if their case went to trial, wouldn't, if
23 they're still alive -- although, frankly, not a whole lot of
24 them are alive -- wouldn't be able to go back and get another
25 x-ray or a high resolution CAT scan, which is a lot more

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1 sensitive for identifying asbestos stuff or pathology or having
2 an expert come in and testify in their case that, in my
3 opinion, you don't need to have radiologically diagnosable
4 asbestosis in order to attribute the lung cancer to the
5 asbestos exposure. That's a big debate in the medical
6 literature. This -- Dr. Weill has one opinion on that score.
7 There are many, many other reputable experts, epidemiologists,
8 pathologists, the people who wrote the Helsinki criteria who
9 have thousands of peer reviewed medical articles to their name,
10 who have a very different opinion.

11 THE COURT: Well --

12 MR. FINCH: And so to the extent that Grace is using
13 this study --

14 THE COURT: The problem with the x-ray submission is
15 that several times during the course of this case I ordered
16 that if there were going to be reliance on an x-ray study, that
17 it be produced now, because at some point in the process the
18 claimant -- the current claimant would have to produce an x-
19 ray. And if it had to produce it to the trust, it could
20 produce it now, and if it hasn't been done, then I said that
21 the assumption for the purpose of this estimation trial would
22 be that it did not exist if it has not been produced. I'm not
23 going to back off that ruling now. That happened several
24 times. The claimants have been given numerous opportunities to
25 produce the evidence of their disease either by x-ray or by

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1 something else, and if they have chosen -- if they have chosen
2 to produce an x-ray, as they were given that opportunity, and
3 have not done it, then at this point they simply do not have
4 that option any longer.

5 MR. FINCH: But the order said for the estimation
6 trial, which is an estimate of Grace's --

7 THE COURT: Yes.

8 MR. FINCH: -- aggregate liability to claimants not
9 any individual --

10 THE COURT: Yes.

11 MR. FINCH: -- claimants. X-rays change over time.
12 People get sicker. People die. People might get pathology
13 when they didn't have pathology before.

14 THE COURT: Yes.

15 MR. FINCH: The point is, Your Honor, that by setting
16 a deadline in March of what you had in your files at this time
17 in a proceeding that everyone was told would (a) not result in
18 the allowance or disallowance of their individual claims, and
19 (b) was for the purpose of estimating Grace's aggregate
20 liability, tells you nothing about the cases would be worth
21 when, as, and if they were resolved by Grace or by a trust or
22 in the tort system, and so we --

23 THE COURT: Well, certainly, it does, Mr. Finch,
24 because to the extent that somebody is going to get more sick,
25 they're either more sick now than they were when the case was

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1 filed in 2001, and to the extent that they -- they're certainly
2 not going to get less sick than they were in 2001. So, if
3 anything, they would be more sick than they were in 2001.

4 MR. FINCH: And they may be more sick in 2008 --

5 THE COURT: They may.

6 MR. FINCH: -- or 2009 --

7 THE COURT: They may.

8 MR. FINCH: -- or 2010.

9 THE COURT: They may.

10 MR. FINCH: And that's why this -- that's the basis
11 for our relevance objection. May I have a -- I think to
12 protect the record under Evidence Rule 103, all I need to do is
13 state the objection as to any testimony based on the
14 questionnaire analysis the first time it comes up and maybe do
15 it on a witness-by-witness basis. There's sort of two aspects
16 of Dr. Weill's testimony. One is this stuff. The other is his
17 PFT statement. Will the Court understand that when I stand up
18 and object on relevance grounds to that, so I don't have to go
19 through this entire spiel? That's what I'm trying to avoid,
20 and I think Mr. Bernick has an interest --

21 THE COURT: Yes.

22 MR. FINCH: -- in trying to avoid that, too.

23 THE COURT: If --

24 MR. FINCH: As long as the record is clear that
25 that's the basis for our objection.

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1 THE COURT: First of all, with respect to the
2 objection concerning the controlling case law on how to resolve
3 claims, the purpose of this testimony is -- as I understand it,
4 is -- at the moment with this witness is not how to resolve
5 claims. This witness is not resolving claims. And so the
6 testimony is not being proffered for that point, and,
7 therefore, the relevance is not to that point. So as to this
8 witness, the relevance objection is not relevant. So it's
9 overruled. You may re-raise that objection when and if a
10 different witness comes up and the proffer is to a different
11 point. You are going to have to do it on a witness-by-witness
12 basis.

13 MR. FINCH: Okay, on a witness-by-witness basis. So
14 when Mr. -- Dr. Florence comes in and relates what this witness
15 or Dr. Henry testified to the resolution of claims --

16 THE COURT: Yes.

17 MR. FINCH: -- that is again when we'll raise the
18 relevance objection.

19 THE COURT: Yes.

20 MR. FINCH: But I do think we have to raise it on a
21 witness-by-witness basis. This is the relevance objection to
22 this witness, and I'll stand on that objection. I understand
23 it's been overruled. Thank you, Your Honor.

24 MR. BERNICK: If you --

25 MR. MULLADY: One additional point of distinction for

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1 the future claimants, Your Honor. To the extent that there is
2 a relevancy objection here, that relevancy point is even one
3 step further removed from the future claimants. The future
4 claimants haven't submitted any x-ray films for review by
5 Grace's experts, yet Dr. Florence's methodology assumes that
6 future claimants in the future will be unable to demonstrate
7 radiographic proof of asbestosis --

8 THE COURT: I understand, but this isn't --

9 MR. MULLADY: -- as an extrapolation from the current
10 claimants.

11 THE COURT: -- Dr. Florence. This isn't the time for
12 that.

13 MR. MULLADY: Understood.

14 THE COURT: Can we please get the objections with the
15 witness who is on the stand at the time the witness is
16 testifying? This is a different witness for a different
17 purpose, and I'm not going to give you advanced rulings with a
18 witness who's not on the stand. So let's get it in the context
19 with the witness who's on the stand. If this is the purpose
20 for trying to get these sidebars, folks, we're not going to do
21 this anymore.

22 MR. MULLADY: That's not the purpose, Your Honor.

23 THE COURT: All right. Then let's limit it to the
24 witness who's on the stand in the context of the witness'
25 testimony. I'm not doing this any longer, folks. This is

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1 ridiculous.

2 MR. BERNICK: Okay.

3 THE COURT: We'll take a five-minute recess. Mr.
4 Bernick.

5 MR. BERNICK: No, I'm happy to adapt to the recess.

6 THE COURT: Do it now.

7 MR. BERNICK: I rather it be clear, so that Your
8 Honor understands where we're going, and we get clarity. First
9 of all, all the objections that go to, well, our experts would
10 say X or Y or Z -- that all goes to the weight of the evidence.
11 It doesn't go to whether it's relevant.

12 Secondly, we are making very spare use of the
13 information that was received in connection with the proof of
14 claim and PIQ process, so that we're working with underlying
15 evidence that ain't going to change with time. Where the
16 witness worked, he knows, and by and large the x-ray evidence,
17 we're not even relying on the B reads. We're looking at the
18 actual x-rays themselves. And, as Your Honor indicated, that's
19 not subject to what experts go out and get. An x-ray is an x-
20 ray.

21 So we're really using very extremely, you know, kind
22 of bedrock hard information that we're getting out of the PIQ.
23 To be clear to the Court, this witness' evidence is providing
24 the foundation for the seven percent, what it is that it means.
25 And based upon that, Dr. Florence will apply the seven percent.

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1 Grace is saying that the people who have submitted the PIQs do
2 not have in their x-rays a medical condition at the time of the
3 x-ray that would lead to liability. It's not there. And
4 because it's not there, the prospect of its ever being there --
5 you can never say never. But for purposes of this estimation,
6 the only evidence in the record will be that these people did
7 not have radiographic x-ray that supported a diagnosis of
8 asbestosis.

9 And Your Honor has been fully consistent with this.
10 They're saying, oh, well, maybe way down the road there will be
11 more, but they're arguing that point in order to defend against
12 our estimate. For purposes of this estimation, Your Honor has
13 indicated (a) they had to provide it, period, but (b) for
14 purposes of this estimation, that is the totality of the
15 record. And so for them to argue that some day, some place the
16 record might be different, and, therefore, this is not
17 relevant, violates squarely the very words that they put in --
18 they suggested be in the order.

19 They're now saying, oh, we can now speculate that
20 there would be more evidence, or we can say the evidence you
21 have isn't any good, and that defeats the whole purpose of the
22 order, which is if you've got evidence, folks, in support of
23 your claim in these areas, you must submit it, otherwise, you
24 are barred from making the argument. They're not making the
25 argument.

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1 So, yes, we will make -- we're proffering this
2 testimony in support of the ultimate exclusion of these claims
3 for the purposes of the estimate. Yes, it's totally consistent
4 with Your Honor's order. Yes, it is relevant under the case
5 law, and if they want to dispute whether a one slash zero
6 really is necessary to diagnose asbestosis -- if they want to
7 dispute that and say you don't even need that -- apart from
8 pathology, you don't need anything but a history, that goes to
9 the weight of the evidence. We don't think that's correct, but
10 that goes to the weight of the evidence. So that's our --
11 that's the full extent of our proffer, Your Honor.

12 THE COURT: All right. We'll take a five-minute
13 recess.

14 MR. BERNICK: Thank you, Your Honor.

15 (Recess)

16 THE COURT: I'm sorry. Please be seated.

17 MR. BERNICK: Is it okay to have Dr. Weill present?

18 THE COURT: Yes. Yes.

19 MR. BERNICK: Okay.

20 (Pause)

21 THE COURT: All right, Mr. Bernick. Dr. Weill.

22 MR. BERNICK: Thank you.

23 DIRECT EXAMINATION CONTINUED

24 BY MR. BERNICK:

25 Q Are you familiar with the work that Dr. Henry did?

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1 A Yes.

2 Q Okay. Do you know what criteria Dr. Henry -- well, first
3 of all, tell the Court what materials -- that is what x-rays
4 Dr. Henry had reviewed during the course of his study.

5 A He examined x-rays that were submitted for a cancer claim.

6 Q In this case?

7 A Yes.

8 Q Okay. Now are you familiar with the criteria that Dr.
9 Henry applied in the course of the study that he did?

10 A Yes.

11 Q Okay. I want to show you GG-2140, and had Dr. Henry took
12 a sample? Is that correct?

13 A Yes, he did.

14 Q And he analyzed that sample to determine what?

15 A He analyzed the sample to determine the prevalence of
16 radiographic asbestosis in the cancer claimants.

17 Q Okay. This chart reflects that he -- reflects a seven
18 percent number over the asbestos box and a 93 percent number
19 over asbestos exposure alone. Does that square with your
20 understanding of the conclusion that Dr. Henry reached in his
21 study?

22 A Yes, it does.

23 Q Now, Dr. Henry will be here to address the details of that
24 study, but for purposes of our discussion here, in concluding
25 that only seven percent of his sample had asbestosis, what

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1 criteria -- precise criteria did Dr. Henry have used during the
2 course of his study?

3 A Dr. Henry, as I understand it, used radiographic profusion
4 category greater than one slash zero to determine if somebody
5 had radiographic evidence of asbestosis.

6 Q Greater than one slash zero or greater than or equal to?

7 A Greater than or equal to.

8 Q Okay. What would then that say about the other 93 percent
9 of Dr. Henry's sample? That is if only seven percent showed
10 asbestosis, what would 93 percent -- what would you be able to
11 say about the 93 percent?

12 A That they had no reliable evidence of parenchymal lung
13 disease, in this case, asbestosis.

14 Q Say no reliable evidence. That is radiological evidence
15 or all evidence?

16 A Radiologic evidence.

17 Q Okay. Let's be clear. So are you aware of any -- as you
18 sit here today, based upon Dr. Henry's work, is there with
19 respect to this group of claimants any reliable radiological
20 evidence that their asbestos exposure, if they had asbestos
21 exposure has had any actual impact on their lung tissue?

22 A No, there's no reliable evidence.

23 MR. FINCH: Objection. Relevance. Same --

24 THE COURT: Yes, overruled. You may answer, Doctor.

25 A No, there's no reliable evidence of that.

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1 Q Okay. Now, apart from radiological evidence in the form
2 of the x-rays, is there other potential radiological evidence
3 that might be used? That is are there other radiological
4 techniques that might be applied?

5 A There are other types of changes in the lung that might be
6 attributable to asbestos exposure, namely, pleural changes.

7 Q Okay. Apart from pleural changes, which we're going to
8 get to, is there any other technique other than an x-ray that
9 would tell you whether there are radiological changes in the
10 meat of the lung?

11 A No.

12 Q Okay. What about non-radiological evidence? Is there
13 other non-radiological clinical evidence -- physical evidence
14 that could tell you that there were changes in the meat of the
15 lung?

16 A You would need pathologic specimens to do that.

17 Q Okay. Did Dr. Henry's study relate to pathologic
18 evidence?

19 A No, not at all.

20 Q Okay. Let's now go forward and take up the question of
21 other kinds of radiological evidence, and I want to direct you
22 to pleural changes. Have you considered pleural changes in
23 relation to lung cancer?

24 A Yes, I have.

25 Q Showing you GG-2142, we've got a slide here that is the

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1 same slide that is showing the seven percent asbestosis
2 evidence, the 93 percent where it's no reliable evidence of --
3 no reliable radiological evidence of lung changes, but then we
4 have a little box marked out for pleural changes. Are pleural
5 changes changes to the lung?

6 A No, they're the changes to the covering of the lung which
7 is called the pleura.

8 Q Okay. Let's talk about those a little bit more
9 specifically. I want to show you GG-2143. Does this slide
10 help you explain to the Court the phenomenon known as diffuse
11 pleural thickening?

12 A Yes.

13 Q Could you explain to the Court that phenomenon?

14 A Diffuse pleural thickening is one of the benign asbestos-
15 related pleural diseases. And diffuse pleural thickening, as
16 the name implies, is a very broad diffuse thickening of the
17 visceral pleura that does not involve the lung parenchyma
18 itself, and by definition, according to the most recent ILO
19 classification scheme put in place in 2000, involves blunting
20 of the costophrenic angle. And I can explain that in more
21 detail, if you want.

22 Q Okay. First let's get our anatomy locations straightened
23 out. You've talked about lung cancer and asbestosis as
24 effecting the meat of the lung. Where we're talking about
25 pleural -- diffuse pleural thickening, where are we in the

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1 anatomy?

2 A So we're where the yellow box shows the arrows. We're in
3 the covering part of the lung.

4 Q And that's called the what?

5 A Pleura.

6 Q Okay. Is that the same thing as the lung tissue, which is
7 subject to lung cancer and asbestosis?

8 A No, it's distinct from that.

9 Q Okay. Is the condition known as visceral -- fibrosis of
10 the visceral pleura, is that asbestosis?

11 A No, it's not.

12 Q Is that lung cancer?

13 A No, it's not.

14 Q Is that a disease of the lung?

15 A No, it's not.

16 Q Does it reflect an impact of asbestos on the lung?

17 A It reflects a change due to asbestos exposure. It's a
18 marker --

19 Q On the lung?

20 A Not on the lung itself.

21 Q Okay. Now, let's talk about what the -- what that looks
22 like on radiograph. Showing you GG-2144, does that help
23 illustrate what is seen on x-ray where diffuse pleural
24 thickening is present?

25 A Yes, it does.

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1 Q Okay. Could you explain to the Court what it is that this
2 shows?

3 A So on the left side of the panel again we have a normal
4 chest radiograph, and on the right side of the slide what we
5 see is that the left lung -- and remember it's reversed. The
6 left is right, and right is left. The left lung shows blunting
7 of the costophrenic angle and thickening of the pleura and
8 would qualify that as diffuse pleural thickening. And it's
9 shown as that white part that's outlined by the dashed red
10 line.

11 Q Okay. What about pleural plaques?

12 A Yes, I did.

13 Q Showing you GG-2145, is this a demonstrative that would
14 help you explain what pleural plaques are?

15 A It is.

16 Q Could you use demonstrative 2145 in explaining to the
17 Court briefly what pleural plaques are and how they fit in
18 here?

19 A Sure. Again, we're not talking about lung tissue here.
20 What we're talking about is the covering of the lung. And
21 opposed to diffuse pleural thickening, pleural plaques are a
22 discreet thickening the pleura itself. So a focal
23 circumscribed thickening of the lung pleura.

24 Q Did pleural plaques reflect a condition of the lung
25 itself?

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1 A No.

2 Q Did the pleural plaques reflect an impact of asbestos
3 exposure on the condition of the lung itself?

4 A No.

5 Q Does pleural plaques, are they even a disease?

6 A No, they're markers of exposure.

7 Q Okay. Are they or are they not significantly associated
8 with the loss of lung function?

9 A No, they're not.

10 Q Are they or are they not an independent risk factor for
11 malignancy?

12 A They're not.

13 Q See radiograph 2146. Would that help explain -- does that
14 help explain what a pleural plaques looks like?

15 A Sure. Again, normal left -- x-ray on the left side.
16 Right side of the slide shows a chest radiograph where there's
17 both right- and left-sided circumscribed pleural plaques, and
18 as the dash line indicates, there is an on-face pleural plaque,
19 meaning it's face on to the chest radiograph.

20 Q Okay. Turning to 2147, based upon consideration of
21 pleural changes, did you reach any conclusion as to whether
22 pleural changes constitute a risk factor for lung cancer?

23 A Yes, I did.

24 Q And what did you conclude?

25 A That they do not increase the risk factor.

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1 Q Now considering also pleural changes with respect to the
2 93 percent of the sample that Dr. Henry looked at concerning
3 these claimants, does it or does it not remain the case, in
4 your view, that there is no reliable radiographic evidence of
5 any impact on the lung itself of asbestos exposure with respect
6 to that 93 percent?

7 A It does not affect it.

8 Q Are you aware of any reliable scientific evidence in the
9 area of radiology that says that there would be such a change
10 given the results of his study --

11 A No.

12 Q -- assuming his study is accurate?

13 A No, I'm not.

14 Q Okay. Now when the seven percent was applied -- are you
15 familiar with this fact? That the seven percent number was
16 then applied in the course of the estimation that was done --
17 the estimate calculation that was done by Dr. Florence?

18 A Yes, I am.

19 Q Okay. I want to show you -- well, first let me just ask
20 you in the following way. We've talked about the fact that
21 there may be people who have other kinds of evidence to support
22 asbestosis, either pathology, slides, or are there other
23 techniques that are involved like CT scans and the like?

24 A Yes, but not specific for asbestosis itself.

25 Q Okay. With respect to this seven percent, we have the

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